MEDICARE AND PHYSICIAN REIMBURSEMENT—A RATIONAL VIEWPOINT: THE AMA PERSPECTIVE*

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THANK you for the opportunity to appear as part of this panel. I know that you have all heard statements on the growth in spending for health services requested by and needed by Medicare beneficiaries. We have all recognized the need for changes in the way Medicare is financed and paid for, so that we and our children, as well as all of the generations that follow them, will be assured that health care will be available and affordable when needed.

Unfortunately, based on our current course, that goal is not realistic. Medicare will go bankrupt. The only question is when. It is not radical to say that the Medicare program, generally, and how we as a nation pay for physician services, specifically, must be revamped. We do not doubt that changes are in the air. Indeed, organized medicine is at the forefront of those who say that now is the time to take positive steps to assure that there will be a sane environment for the future both to receive and to provide medical care services. We are still in the early stages in an era of change, and the medical profession is striving to set the agenda for how medical care will be delivered and paid for well into the future.

Even though medicine has taken the lead by initiating a course to outline a future health policy agenda, society today is surprisingly blind to the future needs. This is exemplified by the actions of the administration and congress as they seem continually to wrestle with Medicare program modifications by focusing on short-term program savings instead of program reform. This directive is particularly hazardous in light of the impending bankruptcy of the Medicare program. While the latest report of the Medicare trustees says that the part A trust fund will be insolvent in the year 2002, governmental action has continued to focus on short-term proposals that

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promise some meager savings. The end result of such action will only be bankruptcy delayed, but not avoided. Before pointing to where changes in direction should lead us, let me discuss how we got to the point where we are today.

Since 1980 we have witnessed an alphabet soup of Medicare modifications that were based on a perceived need to achieve budget savings as opposed to a need for legitimate program changes. From the Omnibus Budget Reconciliation Act of 1980 to the Omnibus Budget Reconciliation Act of 1986, the Medicare program has witnessed literally hundreds of changes, including hospital DRGs and physician reimbursement and fee freezes. The latest go-around has resulted in a totally unique system of limits on physician charges known as—and I say this with apologies to Ray Kroc—"the big MAAC attack." Frankly, physicians and the AMA are sick and tired of the seemingly constant sniping at physicians as a target for budget cuts.

I believe that we rapidly are approaching the point where the impact of these cuts will extend far beyond the individual physician's pocketbook and reach the point where beneficiaries clearly will suffer. Already it is possible to point to isolated cases where past physician fee and reimbursement freezes have resulted in beneficiaries losing access and severing long-term relationships with physicians. I am afraid that these isolated cases will become much more common in the near future. Furthermore, there is a very real potential that this seemingly constant tinkering will move us into a two-tiered health care system where our elderly and disabled will be second class citizens.

Medicare now has reached a point where beneficiaries can get care from two different physicians, have assignment taken on all of their claims, and find that the government pays 4% less for one patient's care based simply on the status of the physician, whether that physician is participating or not participating. A further insult is that the amount allowed for the payment and charged if the care is provided by a non-participating physician may have no bearing on what is charged to other patients for the same service. The point I am making is that the payment amount allowed by the Medicare program has little relationship to reality. The maximum amount that Medicare allows, the prevailing charge (and I use the term prevailing with large red quotes around it), has been the subject of continual tinkering since 1969. While the term "prevailing charge" had some basis in reality at that time, congressional actions have moved this amount from the point where it encompassed most charges in the community to one that frequently is well be-

low the 50th percentile of customary charges in the community. This fact, coupled with the current budgetary pressures to find even more savings in the physician payment component of Medicare, demands that actions be taken in looking to change the mechanism for determining payment amounts under the Medicare program.

Of course, the push to change the way in which Medicare pays for physician services is not all based on the fact that the program under-reimburses for services provided. I am sure that some in the audience can point to specific services and say that the program pays too much for these services. In fact, there is a lot of truth in both statements, and that is why the AMA is taking a lead role in calling for major structural reform. The current system is inflationary, complex, unpredictable, and fraught with distortions. Tinkering with this system may cause even more problems. The correct approach is to scrap it and start over.

The one fundamental principle that the AMA follows in endorsing payment reform is that reform must be based on rational actions. Change should not be made for the sake of change itself. Rash proposals, such as the proposal put forward by the Office of Management and Budget to pay for the physician services provided to hospital inpatients on the basis of DRGs, and even the administration's compromise raps proposal, could prove to be far more detrimental than beneficial. The AMA believes that the future direction for physician reimbursement and payment should be an indemnity fee schedule structured from a well constructed and agreed upon resource-based relative value scale.

Like other professionals, physicians should have the right to establish charges appropriate for their services. However, that right is accompanied by a responsibility to make those charges fair. Thus, the AMA urges physicians to consider each patient's financial condition when setting fees and to accept Medicare assignment, to reduce fees, or to charge no fee at all for those with low incomes.

Acceptance of third-party payment as payment in full—assignment—should remain an option available to physicians on a case-by-case basis. Both physicians and patients should retain this freedom of choice, which ensures access to the largest possible number of physicians. According to data from the AMA's Socioeconomic Monitoring System, 86% of American physicians treat Medicare patients. Many elderly Medicare patients are able and wiling to pay a physician's regular charges, and they should have the freedom and responsibility to choose to do so. Of course, patients should have the

opportunity to receive care from physicians who will accept assignment. According to AMA data, 81.2% of physicians accept assignment for some or all of their Medicare patients. According to Health Care Financing Administration data, approximately 70% of all Medicare Part B charges were assigned in 1986.

The AMA encourages open discussions between physicians and their patients about both fees and Medicare payments. Such discussions would be easier, and hence more likely, if the Medicare allowed fees were more predictable. Thus, desirable competition would be enhanced. Under an indemnity-based reimbursement system, this goal could be achieved. This is particularly true when that system is based on a relative value system that reflects actual resources that constitute the cost components that go into the specific service provided.

Specifically, the AMA supports payment for physician services under the Medicare program using an indemnity system based on a defined schedule of allowances. Such schedules should be based on a relative value study that reflects the resource costs of providing physician's services, and should allow appropriate regional differences in allowances to reflect differences in the costs of practice. The system would indemnify patients for covered services, maintaining the ability of physicians and patients to enter into individual contracts. This system would involve discussions between patients and physicians regarding the physicians' usual charge, Medicare allowed amounts, and the acceptance of the allowed amounts as payment in full.

Development of a Relative Value System

There are now two major approaches to development of a relative value system: historical *charges* or the *costs* of producing each service.

A charge-based relative value system could be developed by using physician charges for a given year. Such a system is feasible since new national data bases are available. However, using charges would maintain distortions already embedded in the Medicare Customary, Prevailing and Reasonable system. However, if the demand for change does not abate, the AMA could support, on an interim basis, a charge-based relative value system fee schedule in preparation for a resource-based schedule.

In contrast to a charge-based system that will maintain historic differentials, a relative value system based on the resource costs of producing physician services is conceptually appealing. Payments based on such a system would more closely reflect the relative costs of providing these services.

A resource-based relative value system is currently being developed by Harvard University investigators funded by The Health Care Financing Administration; the AMA is a subcontractor to the project. Technical consultant groups of physicians in 30 specialties and subspecialties are actively participating in the study. During the first technical stage of the study, data on the resource costs of providing physician services are being collected and analyzed. The resource costs of each physician service include: the time involved in providing the service or procedure (including preoperative and postoperative time); the intensity of the service (defined as encompassing technical skill, physical and mental effort, judgment, and risk to the patient); the amortized cost of specialty training (based on length of residency training, mean working lifetime from graduation to retirement, earnings by specialty, etc.); and the overhead costs of practice (including professional liability insurance premiums).

Data on the first two resource cost inputs are being collected by a national survey of approximately 3,000 physicians, while data on the other two resource costs are being gathered from a variety of other sources. Once collected, the resource cost data will be combined mathematically to develop relative values.

The Harvard/AMA project will use a consensus approach in its second stage to evaluate the results of the technical development of the resource-based relative value system. Consensus panel members will be physicians, third-party payers, business and labor representatives, and health-care related professionals. The system resulting from the Harvard study will cover 17 specialties and approximately 90% of Medicare claims. The planned completion date is July 1, 1988. Once the relative value system resulting from this study is properly evaluated, the resource-based method could be extended quickly to the remainder of physician services.

Support for a resource-based relative value system. The development of a resource-based system has the strong backing of the physician community. Approximately 50 national medical specialty societies are participating at some level in the Harvard/AMA study. The AMA is actively involved in many aspects of the overall project. Congress also has shown considerable interest in this approach. At an American Hospital Association meeting in February 1987 Senator Robert Dole commented that a Medicare fee schedule based on a relative value system that considers geographic variations as preferable to "carving out" hospital-based physicians with DRGs. More generally, Omnibus Budget Reconciliation Act (OBRA)—the 1986 version—

extended the Department of Health and Human Services deadlines for relative value system development and possible implementation until after the Harvard/AMA study is completed, allowing time for appropriate review and implementation of the study's findings.

Updating a relative value system. After a system is completed, it must be updated to account for new technologies and practices, including the elimination of services no longer in use. Updating for new technologies on a short-term basis is necessary for the system to reflect the most current medical advances, but annual reconstruction of the entire system would be too expensive and disruptive. Thus, a method will be needed for short-term revisions. In addition, the *entire* relative value system should be revised periodically. The approach could resemble that used in Medicare's prospective pricing system, in which both the weights associated with the DRGs and the DRGs themselves are recalibrated. The same general approach should be used to recalculate a relative value system as was used in its original development.

Coding. Any relative value system must use a system of procedural coding and nomenclature to describe the services that physicians actually provide to patients. This coding system would be the basis for establishing the relative values among the services. The Health Care Financing Administration has already taken the first step toward a universal coding system by requiring carriers to use its Common Procedure Coding System for Medicare claims. This includes the AMA's *Physicians' Current Procedural Terminology*, 4th Edition (CPT-4). CPT-4 is developed and maintained by the CPT-4 Editorial Panel, which includes representatives of the American Hospital Association, the American Medical Association, the Blue Cross and Blue Shield Association, the Health Care Financing Administration, and the Health Insurance Association of America. CPT-4 is updated annually, and HCFA's Common Procedural Coding System (HCPGs) incorporates those revisions.

Monetary conversion factor. No matter how a relative value system is developed or updated, the monetary conversion factor is critical. This factor converts the system into an indemnity schedule. The conversion factor could be modified by a multiplier or a set of multipliers to refine the schedule. If conversion factors are used to help achieve Medicare expenditure goals, policy makers must take care to maintain access to high quality care for the Medicare population.

Geographic variations. One potential refinement would address the current geographic differences in Medicare fees and payments. Geographic variation in Medicare allowed amounts should be examined for appropriateness. Multipliers should be applied to the monetary conversion factor to reflect

variations based on differences in costs. Application of these multipliers could be used to create, preserve, or eliminate regional differentials and urban and rural differentials. The specific issues of the number and definition of regions and urban and rural differences are currently being studied by such groups as the AMA, the Health Care Financing Administration, and the Physician Payment Review Commission.

Updating the conversion factor. The monetary conversion factor must also be updated to allow for inflation and other factors. One approach to such updates would be an index of input costs. The current Medicare Economic Index is one example of such an index, but it has been criticized for deficiencies in its construction and its use of 1973 prevailing charges as a base. An alternative approach could involve a process of negotiations. Any updating mechanism for the conversion factor should reflect physician costs and allow continued access to high quality medical care.

Implementation. A new relative value-system-based payment schedule could be introduced over a period of time to minimize disruptions for patients and physicians. Just as the Medicare hospital prospective pricing system has been phased into operation, the implementation of a physician fee schedule under Medicare could occur in stages.

Indemnity system. The AMA believes that payment schedules should be used in an indemnity system in which physicians could charge patients their usual fees, Medicare indemnifying patients for their expenditures according to a specified schedule. In instances of financial need, the indemnity approach will focus appropriate consideration by the physician, and make individualized adjustments and the acceptance of assignment more likely. Physicians must set their fees to cover their costs of practice, such as office mortgage or rent, nurses' and other employees' salaries, office equipment, supplies, professional liability insurance premiums, and other costs. They also take competitive pressures into account, a factor that will be increasingly important under an indemnity system.

An indemnity system would provide several advantages for patients, physicians, and Medicare, including: continued access to care through market forces rather than ever more complex regulation; increased sensitivity to costs and quality of care for physician and patients; greater understanding of physicians' charges and Medicare payments through discussions between patients and physicians, facilitated by the predictability of Medicare allowed amounts; and simplified administration by Medicare.

Data collection. Two factors that make even the concept of a resource-based relative value system feasible are improved data collection and an improved ability to use this data. When the Tax Equity and Fiscal Responsi-

bility Act was passed in 1982, The Health Care Financing Administration recognized the inadequacy of its data base for addressing its expanded assignments. Following study, a decision was made to modify and expand its data files. Four of these files have become known collectively by the acronym "BMAD" (Part B Medicare Data). Effective July 1984, carriers were required to provide the Health Care Financing Administration with the necessary data to update these files on an annual basis, concurrent with the carrier's reasonable charge update cycle. The Health Care Financing Administration, in turn, is developing BMAD into a modern on-line system with software capability for access by individual carrier and in the aggregate. Whereas heretofore approximately 50 different files had to be accessed individually to compile aggregate figures, the new system will allow immediate access to the data. More timely and sophisticated information will result.

BMAD has the potential to become one of the most powerful of HCFA's data systems. Its four core components are: *beneficiary file*, which will initially contain data on 5% of beneficiaries, such as the bill summary record, claims detail about all end stage renal disease beneficiaries, and HCFA's Common Procedure Coding System's procedure codes. It allows The Health Care Financing Administration to link a beneficiary's Part A and Part B services utilization data. *Provider File*, composed (initially) of a 1% sample of providers (physician and non-physicians) entitled to Part B payments with all of their services charged to Medicare patients. It accumulates data on each sampled physician over several years, allowing longitudinal analysis of impact of actual and projected program changes upon physicians and suppliers. Currently this data is maintained on approximately 6,000 individuals. *Provider File*, which accumulates the information on each procedure code in HCFA's Common Procedure Coding System by each carrier, with its frequency, the charge, and the amount paid. *Prevailing Charge File* is designed to reflect the prevailing charge limits for every procedure by each carrier. It allows the Health Care Finance Administration to study and accurately project payment levels.

Conclusion

In conclusion, I want to leave you with a thought that physician reimbursement reform is but one item in a very large picture. A major element of this picture is that the Medicare program can ill afford yet another repetition of budgetary cutting and squeezing while simultaneously ignoring the major issue of the future of this program.

As I said earlier, it is no longer shocking to hear predictions that the Medicare program is heading for fiscal bankruptcy in the future. The unanswered

question is exactly when the program will run out of funds. Whether that point is to be reached in the year 2002 or 2010 is irrelevant. What is relevant is that bold steps must be taken to avert a situation where the coming generations of Americans will have paid into the Medicare program for their entire working lifetimes only to discover that Medicare is no longer able to meet their needs. The American Medical Association has recognized this fact, and has embarked on an intensive process to examine this problem and to come forward with ideas designed to assure a sound program that will guarantee the provision of health care services for coming generations when they reach the age of Medicare eligibility.

Our analyses indicate that it is time to acknowledge the widening generation gap, the inherent problems of the current intergenerational transfer of resources, and the improved financial circumstances of the elderly relative to the working young.